The Healing Center - Pediatric History

(303) 721-9800

Name: _____ Sex: M F Date: _____

Date of Birth: _____ Age: _____

Street: _____ City/State/Zip: _____

Phone C: _____ H: _____ Email: _____

Who Referred You to the Healing Center? _____

Mother's Name: _____
Last First Middle Initial

Father's Name: _____
Last First Middle Initial

Work Phone (parents): _____

Present History

Purpose for this appointment: _____

Child's overall diet: _____

Known reactions to food/environment: _____

List all traumas/falls/accidents/surgeries & age _____

_____

_____

Any Past Medications: _____

Current Medications: _____

Current Supplements: _____

Treatments used & their outcome: _____

Birth History

Delivery: ☐ Normal ☐ Vaginal ☐ Forcep ☐ Vacuum ☐ Breech ☐ Cesarean

Any complications during delivery? _____

Infant Feeding: ☐ Breast How Long? _____

☐ Formula How Long? _____ Type: _____

Congenital Anomalies/Defects: _____

Date of last MD visit: _____ Purpose: _____

Has your child been vaccinated? YES NO Which ones? _____

_____ Any reactions? _____

Check any of the following conditions your child has suffered from:

☐ Ear Infections	☐ Chronic cough	☐ Seizures	☐ Eczema/Psoriasis	☐ Headaches
☐ Sinus Problems	☐ Dark circles below eyes	☐ ADD/ADHD	☐ Recurring Fevers	☐ Growing/Back Pain
☐ Chronic Colds	☐ Failure to thrive	☐ Car Accident	☐ Temper Tantrums	☐ Extremity Problems
☐ Food Allergies	☐ Colic	☐ Hives/ Rashes	☐ Mood Swings	☐ Scoliosis
☐ Digestive Problems	☐ Misc. infections	☐ Asthma	☐ Rapid shift in temperament	☐ Bed Wetting

Authorization for Care of Minor

I hereby authorize this office and its doctor(s) to administer care as they so deem necessary to my son/daughter.

Signed: _____ Witnessed: _____ Date: _____

I realize that I am responsible for all fees charged by this office and that I will pay for all services as they are performed. If my account is sent to collections, I will pay attorney and collection fees.

Signed: _____ Witnessed: _____ Date: _____

Metabolic Assessment Form Key

(303) 721-9800

Name: _____ Age: _____ Sex: _____ Date: _____

Please list the 5 major health concerns in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Please circle the appropriate number "0-3" on all questions below. 0 as the least/never to 3 as the most/always.

Category I: Colon				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3
Category II: Intestinal Integrity				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredicatable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3
Category III: Chemical Intolerance				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3
Category IV: Stomach - Hypochlorhydia				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables: undigested food found in stools	0	1	2	3
Category V: Stomach - Hyperacidity				
Stomach pain, burning, or aching 1-4 hrs after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digesting problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, and caffeine	0	1	2	3
Category VI: Small Intestine/Pancreas				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3

Category VII: Biliary				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the AM	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	0	1	2	3
Category VIII: Sugar Metabolism				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery , or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	Yes		No	
Category IX: Insulin Resistance				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3
Category X: Adrenal Hypofunction				
Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3
Category XI: Adrenal Hyperfunction				
Cannot fall asleep	0	1	2	3
Perspire easly	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration w/ little or no activity	0	1	2	3

Child Neurotransmitter & Nutrition Questionaire (CNNQ) (303) 721-9800

THE HEALING CENTER ALLERGY & PAIN CLINIC

Name: _____ Age: _____ Sex: _____ Date: _____

* Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.

SECTION : GENERAL

- Does your child have any food sensitivities or allergies? (please list)

  _____

  _____
- List your child's 4 healthiest foods eaten regularly

  _____, _____,

  _____, _____
- List your child's 4 unhealthiest foods eaten regularly

  _____, _____,

  _____, _____
- How many times a week does your child eat candy? _____
- How many times a week does your child drink soda pop? _____
- Please list the top 4 foods your child craves regularly?

  _____, _____,

  _____, _____
- List the medication(s) your child is currently prescribed and over the counter

  _____

  _____
- Do you find it difficult as a parent to have your child on a special diet?

  _____

SECTION : A (K52)

- Does your child eat pasta, breads, and breaded foods? 0 1 2 3
- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating wheat foods? 0 1 2 3
- Does your child eat dairy products? 0 1 2 3
- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating dairy products? 0 1 2 3

SECTION : B (K53)

- Does your child eat fried fish? 0 1 2 3
- Does your child eat roasted nuts or seeds? 0 1 2 3
- Is your child missing essential fatty acid rich foods in his/her diet? (for example: avocados, flax seeds, olives) (mark "0" if present, "3" if missing) 0 1 2 3
- Does your child eat fried foods? 0 1 2 3

SECTION : C (K34)

- Is your child's mental speed slow? 0 1 2 3
- Does your child have difficulty with learning or memory? 0 1 2 3
- Does your child have difficulty w/ balance and coordination? 0 1 2 3

SECTION : D (K16)

- Does your child have stress? 0 1 2 3
- Does your child not have enough sleep and rest? (mark "3" if not enough) 0 1 2 3
- Does your child not have regular exercise? (mark "3" if no exercise) 0 1 2 3
- Does your child feel overly worried and scared? 0 1 2 3

SECTION : E (K16, K51)

- Does your child have temper tantrums? 0 1 2 3
- Does your child exhibit wild behavior? 0 1 2 3
- Does your child frequently yell or scream for unnecessary reasons? 0 1 2 3
- Does your child have an inability to nap or sleep when physically exhausted? (mark "3" if unable) 0 1 2 3
- Is your child overly talkative? 0 1 2 3
- Does your child fidget and squirm when seated? 0 1 2 3
- Does your child run and climb excessively when it is inappropriate? 0 1 2 3
- Does your child have difficulty playing quietly or engaging in leisure activities? 0 1 2 3

SECTION : F (K51)

- Does your child get excited easily? 0 1 2 3
- Does your child have anxiousness and panic for minor reasons? 0 1 2 3
- Does your child feel overwhelmed for minor reasons? 0 1 2 3
- Does your child find it difficult to relax when she/he is awake? 0 1 2 3
- Does your child have disorganized attention? 0 1 2 3

SECTION : G (K50)

- Does your child seem depressed? 0 1 2 3
- Does your child have mood changes with overcast weather? 0 1 2 3
- Does your child have symptoms of inner rage? 0 1 2 3
- Does your child seem uninterested in games/hobbies? 0 1 2 3
- Does your child have difficulty falling into deep restful sleep? 0 1 2 3
- Does your child seem uninterested in friendships? 0 1 2 3
- Does your child have symptoms of unprovoked anger? 0 1 2 3
- Does your child seem uninterested in eating? 0 1 2 3

SECTION : H (K49)

- Does your child have difficulty handling stress? 0 1 2 3
- Does your child have anger and aggression while being challenged? 0 1 2 3
- Does your child feel tired even after long sleeps? 0 1 2 3
- Does your child tend to isolate from others? 0 1 2 3
- Does your child get distracted easily? 0 1 2 3
- Does your child have constant need and desire for candy and sugar? 0 1 2 3
- Does your child have disorganized attention? 0 1 2 3

SECTION : I (K48)

- Does your child have difficulty with visual memory? 0 1 2 3
- Does your child have difficulty remembering locations? 0 1 2 3
- Does your child have fatigue or low endurance for learning activities? 0 1 2 3
- Does your child have difficulty with attention or low attention span or endurance? 0 1 2 3
- Does your child have slow or difficult speech? 0 1 2 3
- Does your child have uncoordinated or slow movement? 0 1 2 3

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only